Assisted Living Regulations
Public Forum – Session One
August 27, 2015, 2:00 p.m.- 4:30 p.m.
Meeting Minutes

Regulation Review for COMAR 10.07.14 (Sections .01 - .14)	
OHCQ Staff:	Amanda Thomas (Organizer), Regulatory Affairs Analyst Chrissy Vogeley, Chief of Staff, Gwen Winston, Quality Initiatives Coordinator Jasmin Watson-El, Executive Associate Carol Fenderson, Deputy Director of State Programs Patricia Tomsko Nay, Executive Director, OHCQ
Date:	August 27, 2015
Time:	2:00 p.m. – 4:30 p.m.
Location:	Rice Auditorium, 55 Wade Ave, Catonsville, MD 21228

Welcome and Introductions:

- Opening remarks and welcome - Dr. Nay
- Review of Ground Rules – Amanda Thomas
  - Please note that this session is being recorded for note taking purposes.
  - Please be respectful during this session. Everyone's comment is important.
  - 2 minute time limit for comments.
  - Those in the room will provide comments first and those on the phone will follow.
- Change to the agenda
  - Regulation .05 is moved to the end of the agenda due to time constraints.

Attendees:

- 90 attendees participated in person
- 49 attendees participated by phone

Akinoni Ayodele	**Maroulis, Akrivi**
Anthony Felicia	**Marshall, Gail D.**
Arrington, Anne	**Mayer, Tim**
Bainel, Flora	**McArthur, Yvette**
Barnes, Tracee	**McCamie, Lynn**
Bennett, Eileen	**McKeon, Jack**
Betz, Erin	**McShane, Phyllis**
Boettger, Susan	**Meekins, Kimbra**

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Brocato, Barbara	**Miguel, Marilu**
Brown, Julia	**Moore, Lina**
Burton, Kim	**Moran, Theresa**
Carter, Richard	**Moshier, Gretchen**
Carter, Yvette	**Nakagama, Mary**
Cashour, Eileen	**Neal, Tamara**
Caswell, Carolyn	**Noh, Son**
Coley, Albertha	**Nolan, Claire**
Cotterman, Marjorie	**Ogunduyilemi, Madgan**
Cummings, Renita	**Ojekanmi, Funmilola**
Czajkowski, Nancy	**Palmer, Mary**
Dent, Mary	**Parry, Florence**
Derosier, Rosann	**Peters, Lois**
Ditman, Christina	**Plutschok, Joyce**
Dobson, Lucy	**Ponterio, Diana**
Dunn, Sister Irene	**Praileau, Donna**
Elben, Linda	**Ravenell, Cassandra**
Ellis, Stevanne	**Rich, Robin**
Gathogo, Anita	**Rich, Robin**
Geer, Joyce	**Roup, Brenda**
Gill, Livleen	**Sackett, Amanda**
Hamilton, William	**Sathya, Daphne**
Hayden, Kathy	**Savage, Marie**
Hemler, Patricia	**Simms, Mae**
Hogue, Lance	**Sraver, Warren**
Holmes, Delores	**Tayman, Bobbi**
Jackson, Jennifer	**Vaughan, William**
Jaskot, Emily	**Weaver, Clarence**
Kaiser, Nicole	**Williams, Wayne**
Kauffman, Danna	**Woodson, Michelle**
Kelley, Dellores	**Young, Donna**
Kennedy, Julie	**Young, Steve**
Kerriem, Shareba	**Younger, Pat**
Kim, Julie	**Zeiss, Heather**
King, Elizabeth	**Zick, Rebecca**
Lakin, Karin	
Leonard, Jeanne	
Mansour, Daniel	

Review of Regulations

.01 – Purpose

- No comments

.02 – Definitions

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- Phyllis McShane, MD Dietetics and Health Care Communities and Marie Savage, Board of Dietetic Practice
  - Add new definition for licensed registered dietician from the Title 5 Annotated Code of Maryland.
- Steveann Ellis, Office of the State Ombudsman Program
  - It is important for regulations to be person-directed and person centered to reflect what the resident wants in the facilities.
  - For both 6 and 7 –Alzheimer's and dementia special care would be helpful, that way it includes all types of dementia.
  - For case management, it would be helpful to get clarification as to why this was added because case management is so broad in the community; there are so many different kinds of case management. It is understood to be interchangeable throughout the regulations.
  - For facilitating access, the definition says means and then goes into what is DOESN'T mean, so there needs to be an actual definition for the term.
  - Financial exploitation, first place resident representative is being mentioned. It is important for the resident to be involved in decision making. Please say resident and/or resident representative or legal agent where appropriate.
  - For health care practitioner, that term is so broad, who is that?
  - Incident – please list what incidents are. Omit "resulting in injury" to have it just say assault.
  - Definition of restraint (comment also from the Dept. of Aging): add language that drugs and or chemicals may not be used as a convenience to staff to discipline residents.
- Donna Young, AL Facility Owner
  - Under criminal history, identify things that are eliminating factors and time period used in criminal background check. Sometimes people have done things in their youth that are not serious offences that should not eliminate them from consideration.
  - Specify list of facilities that can be used to get background checks done. Update a link to available facilities and keep it up-to-date. Clarification that says if a provider is not on the list is it ok to use them for a check.
- Kim Burton – MD Coalition for Mental Health and Aging
  - Insert definition of Behavioral Health. Willing to negotiate on what that means. However, the definition offered by BHA is narrow for what we hope behavioral health covers in Assisted Living. Current term should include mental health, addiction and brain injury. Also needs to be used throughout the regulations.

- Add to definition of chemical restraint – means the administration of drugs with the intent of significantly curtailing the normal mobility, physical activity or behavior of a resident in order to protect the resident. This is because we know that chemical restraints are often used when individuals are agitated or distracted. Reflect what behaviors are needed for chemical restraint.
- Add to definition of health condition to include behavioral. The definition would read status of a resident's physical, cognitive and behavioral well-being. This will be in sync with current terminology and realms of health they believe will be assessed and addressed.
- Page 52, b4- Change language to add mental, behavioral and cognitive to the definition in keeping with terminology and in line with the domains of assessment.
- Page 72-1, Aii2 - Add cognitive and behavioral health to the definition.
- Page 79A, Add cognitive and behavioral to definition.

- Commenter
  - Staff – direct care staff be at minimum certified nursing assistants.
  - Under criminal background check, included in language, periodic checks (annually or maybe 3 years) or rap backs.
- Senator Delores Kelly
  - Not all staff is appropriately aligned in the current regulations. We need to include those in AL facilities who are not ill but are there after retirement and other social reasons. Not everyone needs to be treated as an ill person.
- Tracy Barnes, AL Manager
  - Un-stageable pressure sores added.
- Phone Caller
  - No definition of who is considered unlicensed, need to add this.
  - Should say certified and licensed medication technician.
- David Jones, Board of Pharmacy
  - Support the expansion of definition of chemical restraints.
  - 3B under medication administration, definition is limited to operational issues, need some clinical issues included like patient rights in section i, ii, and iii.
  - Self-administration, note that there should be documentation that the resident understands and has accomplished self-administration of medication.

.03 – Incorporation of Reference

- No comments.

.04 – Licenses Required

- Senator Delores Kelly
  - Definition of Assisted Living is so broad. Licensure should apply to those who employ AL services. They should not be caught up in a medical model in which this does not apply, like seniors who are living in AL facilities because they are afraid to live alone or due to retirement, etc.
- Commenter
  - Section E, short-term residential care. If staff is a family member who already lives there, are they counted in the stats as a resident? Please give clarification. Under section F: does drug license have to be posted? This should be included so that people understand that they have to apply for that license, it is required.
- David Jones, Board of Pharmacy
  - Make sure drug licensure requirements are clearly stated. Personnel files should be updated and current.

.05 – Section moved later in the agenda.

[.06] .05 Restrictions

- Commenter
  - Add in clarification for the drop-in day services section, little contradictory. If an AL facility cannot provide day services, how can it say if they are accepted? What about respite care residents?
  - Respite care - "Could not exceed 30 days for the entire year" – how does that work if they are not living in the home but staying while family is on vacation or something.

[.07] .06 Licensing Procedure

- Commenter
  - Add drug license requirement.
  - Board of Pharmacy seconds the comment.
- Caller
  - In order to be licensed should be required to have liability and hazard insurance. Tags into the emergency preparedness for facilities.

[.08] .07 Changes in a Program that Affect

- Commenter
  - There is nothing to give a clear definition of program changes. Does it include changes to services? Does it include name changes, like changes in the facility's alternate?

[.09] .08 Licensure Standards Waiver

- No comments

[.10] .09 Uniform Disclosure Statement

- Commenter

- What is required to be changed/updated in the statement within the 30-day period? Allow document form resources to be available in WORD form document so that facilities can update, if needed.

[.11] .10 Investigation by Department

- Commenter
  - Regulations say open and accessible at any point in time. If there is a portion that is not utilized as part of the AL facility, why should it be available for inspection? Clarify what employee records should be out and available unannounced and announced.
- Commenter
  - Remove the word "staff" from this section. Often facilities have a headquarters location. So, as long as they are easily accessible, there should be no problem.
- Emily Jascott, MD Legal Aid
  - Change to explicitly state a program and all of its records should be avail to ombudsman and MD Disability Law Center. Some programs deny entry to ombudsman hindering their ability to advocate for residents.
- Senator Delores Kelly
  - Ombudsman went unannounced and no one asked who she was and did not ask for identification.
- Commenter
  - OHCQ should follow-up a second time with complainants before handing down the final word because OHCQ tends to just take the word of the AL facility. Complainant may have additional information to rebut the decision that OHCQ has come to.
  - Accountability for employment background checks. Employees commit crimes and go to new facilities. This is related to rap-backs. They are needed so that people cannot go to new facilities after being convicted of crimes.
- Commenter
  - Clarification on process for IDR and timeline as well. Once the findings are sent for IDR, if you are still in disagreement, what is the process?
- David Jones, Board of Pharmacy
  - Would like to see something with what licensee must post in regards to their survey findings. For example, the Plan of Corrections (POC) and if POC was accepted.
- Caller
  - In regard to records for staffing, what is required needs to be specified. Only certifications need to be kept. Personnel files include information like background checks, social security, bankruptcy, direct deposit, etc. That is

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inappropriate to be kept open and accessible at all time. Those present at the IDR need to be documented and in the definitions section at the front. Is there an appeal process following the IDR?

- Commenter
  - The family should be notified if the surveyor finds an injury/harm to the resident?

[.12] .11 Compliance Monitoring.

- Steveann Ellis, Ombudsman
  - Clarify that ombudsman is not an agent of OHCQ but do inspections for the benefit of the resident.
- Caller
  - Routine inspections should be announced because if they want information and the manager is unavailable, they do not have access.

[.13] .12 Administration

- Commenter
  - For quality assurance, the delegating nurse and other staff should meet quarterly because of the acuity of AL residents. Facility staff should be present if requested by family council or resident and should respond to the council in writing if grievances are submitted by family or council.
- Karen Larkin, Provider
  - Resident plans should be reviewed at an ongoing basis, as needed and not just during quality assurance meetings. Greater focus on quality assurance. Reconsider the language in quality assurance in its entirety.
- Daniel Lunsfor, Consultant Pharmacist
  - Outcomes of Pharmacy reviews – expand the section to include assessment on consult. Also have a review more often than 6 months. Review should be every 15-30 days.
- Commenter
  - When the family decides to use their own pharmacy and not the facility pharmacy, should the facility pharmacy have to do a review of that resident who is not under their watch? How is the facility to remain in compliance if their pharmacy does not want to do that review?
- David Jones, Board of Pharmacy
  - Section 2A, Consultant pharmacist should be an active participant on any review and recommendation. Every 3 months review, more often if doable. Consultant pharmacist doing chart review, be independent of pharmacy providers so that there is no conflict of interest.
- Caller
  - In regard to signed physician medical order forms, do they have to come from the pharmacy?

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- Marlena Hutchinson, Deputy Director of Nursing and Waiver Services
  - Agrees that the section on Quality Assurance needs to be strengthened including having frequency be at least 3 months or greater.
- David Jones, Board of Pharmacy
  - Designate a time period that the physician medical order is in effect (3 months, 6 months, etc.).

[.14] .13 Staffing Plan

- Michelle Woodson, Health Professional and Private Citizen
  - Use of the term "sufficient staff", is subjective and depending on the program, there may be 5 aides to 80 residents and somewhere else, there may be 2. Electronic monitoring system , once approved, the mechanism to ensure that it is actually working is checked periodically.
- Daniel Lunsfor, Consultant Pharmacist
  - Section E, 6 – facilitates the access of the consultant pharmacist to electronic health records and to assist with any information as to change in condition. Mentioned a quote that says any new symptom may be a side effect of a new medication. Need to see full file with history to see if changes could be a side effect of medication.
- Danna Kauffman, LifeSpan
  - Section E is too broad. Need to specifically address the items in this section because they are critical tasks. Specifically outline things like level of staffing. Commenter also submitted written comments.
- Commenter
  - The use of the word "sufficient" is too subjective. Section A – Staffing Plan, does the facility have to actually have a printed copy or is electronic ok? In regard to awake overnight staff, there needs to be something on the form to say this is required or not required for a resident. Section D – Clarification needed. What services require what level of nursing? Give examples. Page 41, section 2, Electronic monitoring – What types of devices are acceptable? Can providers go to home depot and find devices for the door? Give examples. Please offer clarification to define on-site nursing, is it based on levels of care, license (RN, LPM, CNA), etc.
- Phyllis McShane, MD Dietetics and Healthcare Communities
  - Page 39, section E, have it move to Pg. 40 to make a new section (5) – please add additional language "identify, improve or maintain resident nutritional and hydration status". Commenter also submitted written comments.
- Kim Burton, Md. Coalition on Health and Aging
  - Page. 42, section F – in point #2, add in medical and behavioral health services. Psych and substance use disorders can be forgotten. There are

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issues of parody everywhere. Specify parody between medical and mental health disorders.

- Ms. Kareem, Provider
  - Staffing records – requirement for vaccinations- what is required to document or prove immunizations (MMR). What time period is acceptable between immunizations or before updated immunizations is required?
- Commenter
  - Outline awake-overnight staff requirement, qualifications should be outlined and at minimum a CNA.
- Commenter
  - Clarification in section B, relief personnel – "at all times", if someone calls in this morning, should there be someone there already to cover?
- David Jones, Board of Pharmacy
  - Full support of comment about having full access to patient electronic records. Staffing plans should show continuity in medication treatment by the awake-overnight staff.
- Caller
  - Should eliminate electronic monitoring systems for those facilities over 3 residents. Many residents get up at night to go to the bathroom or even fall. A CMT can be hired to administer medication overnight.

[.15 Assisted Living Manager.] Note, this section is replaced by .14 Requirements for all Staff.

- No comments

.14 Requirements for all Staff

- Commenter
  - Staff should get flu vaccines free of charge. Section E, no one should be exempt from annual training requirements. All staff should have training on cultural diversity and sensitivity
- Danna Kaufman, LifeSpan
  - Regs state that timing of training should be done prior to assuming any responsibility for care. This creates an undue burden on facilities to be able to have staff on the floor. There are other ways to accomplish the intent like working with someone until they can be certified competent. Clarification on who can do the training. Maybe revisit the train-the-trainer chart. Transmittals, clarify those who can do services and are under 18 years old. Continue certification by electronic signature for immunizations/vaccinations. Proof of training electronic marketplace, the signature should not be required in the age of electronic training. Commenter also submitted written comments.
- Alberta Coli, Provider

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- Page. 49, there are many internet courses available. The program should make a trained individual available to answer questions. Should clarify that if there are online courses, electronic means may be used.

- Commenter
  - MHA Maryland- Pg. 48, Dementia and Behavioral Health - Require mental health first-aid training
- Commenter
  - Section 4, Criminal background checks – many people have multiple jobs. No rap-backs or periodic background checks. Can be convicted of serious harm charge at one facility and be working at a second facility and that employer does not know.
- Daniel Lunsfor, Consultant Pharmacist
  - SectionD3, all staff should be offered Hepatitis B vaccines.
- Commenter
  - Age limits eliminates allowance of workforce development, youth work and mentoring programs. Electronic training, problem with online classes, one person can be doing the training for everyone. You have no idea who took the class. Internet course also do not allow questions of a person and understanding their interpretation of the material.
- Commenter
  - The number of training hours required for someone to even start work are substantial. It would probably take a good 2 weeks to provide the needed training before getting the employee on the floor. Asks that the training component be looked at again.
- Commenter
  - Drug testing should be required, especially for med-techs. Include training for workplace violence and back injury
- Mary Dent , ABC Training Ctr.
  - Pg. 52, 3A - 80 hours manager course by MHEC is a hardship to those who are already required to get approval for their curriculum. Reconsider taking business away and giving to electronic systems in which people are letting others take the course for them. Emily Jascott, Legal Aid Bureau - Agrees that's mental health first-aid training should be added to the regulations.
  - RNs should get the training as well.
- Commenter
  - Not every situation can or should be decided by regulations. Some things should be decided by the facility, some by the industry. Everyone can have abuses of systems. Let's not box ourselves in so much that helpful electronic means are not available for use.

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- Marlena Hutchinson, Deputy Director of Waiver Services
  - Drug screening should be routine during employment and before hire. Expand background checks to be federal to allow updates for in-state, out-of-state and as they happen.
- David Jones, Board of Pharmacy
  - Add in statutory and regulatory mandates for training. Agree to have drug testing before hire and during employment.

- **.05 Levels of Care**

Dr. Nay, Executive Director, OHCQ

OHCQ has received many comments on regulation .05 Levels of Care both for keeping it and removing it. OHCQ has spoken with about 41 different groups and conducted some preliminary research. OHCQ licensure data shows that as of August, 2015 there are only 3 level one licensed Assisted Living facilities in Maryland. Approximately 91% are licensed as a level 3 facility. This data points to a need for the system to be revised. The current system may not be reflective of the change in industry. See Levels of Care Information Sheet.

- Commenter
  - Clarify the level definition.
- OHCQ Response
  - If you are level 1, you may only accept level 1. Level 2 can accept residents who are level 2 and level 1. Level 3 can accept levels 1,2 and 3 residents.
- Commenter
  - Need standardized tools to determine level of care for resident. If you are a level 2 at one facility, there should be no reason you are a level 3 at another. If you are using that. Have the form calculate the numbers
- LifeSpan and Provider
  - Agrees with Dr. Nay, eliminate levels of care. The meaning to the public is not what it is intended to have. More important to look at residents, service plans and assessments. Even within the levels, there are discrepancies about needs.
- Theresa Moran, Delegating Nurse
  - Supports eliminating the levels of care and using the new tools. It allows better and more comprehensive assessment.
- Sister Irene Dunn, Provider and Delegating Nurse
  - Oversees 6 AL homes that are level 2s. They try not to bring in the level 2 residents to keep costs low for residents who they bring in and makes more beds available. Would like to keep levels of care.
- Commenter

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- Without the levels of care, how are Medicaid waivers impacted? Have to be able to afford to care for residents. How will the level of care be determined?

- OHCQ Response – Facilities may still use the Resident Assessment Tool (RAT) and do the levels of care. OHCQ is working very closely with Medicaid Program so that we do not have unintended consequences with changes.
- Commenter
  - On the website, please post links to the new RAT. For admissions contracts that are based on the levels of care, of they are eradicated, what would be a transition period. Please provide guidance or discussion about that.
- Commenter
  - Include consumers in regulations talks and processes.
- Commenter
  - When nurse surveyors come out and find deficiencies, these are posted. POC's should be posted as well.
  - Provide guidelines on levels of staffing for each level of care.

Other Notes

- No discussion session due to time constraints.
- Regulations not discussed will be moved to the next stakeholder meeting.
- Amanda asked that participants complete the Assisted Living Regulation Review survey.

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